

HARVARD MEDICAL *ALUMNI BULLETIN*

Winter, 1962

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LETTERS

Care for the Aged in V.A. Hospitals

To the Editor:

Untold numbers of individuals now exist because human life has been preserved whenever possible.

Public concern for care of the aged and chronically ill was not dreamed up by the politician as a means of reaching Washington. It evolved as a social problem for which American medicine should shoulder the major responsibility.

Today good health has become a basic right! It is, therefore, time to take stock. Government is in medicine to stay. The Veterans Administration Medical program was designed to care for service-connected afflictions and more recently has made room for the indigent ex-service personnel. It is difficult to obtain these statistics, but an educated guess is that less than 15% of the present beds are occupied legitimately. The percentage is not really relevant, how-

ever. This very large group in our society is growing older and is not being replaced. At some point in the not too distant future, some thought must be directed toward the full use of V.A. medical facilities. If at the same time care for the aged is instituted under sponsorship of the federal government, we have a large group of people for which services will have been duplicated.

The obvious answer then is to merge the medical facilities of the V.A. with the needs of the Health and Welfare Department and thereby reduce the need for increasing "socialized medicine." In doing so, the group most readily made to "suffer" will be the younger veterans now in the prime of their lives and at their most productive period financially. The amoral policy of caring for the veteran when he is financially most solvent would be abandoned. This suggestion is likely to meet with howls of anguish from Veterans' organizations and from politicians. It is far better that these groups be

offended, than the physicians who have supposedly dedicated their lives to a humane endeavor.

Here, then, is a program, simple in its conception. It places the burden on society to recognize the justice of this plan. It places the medical groups in a position of positive thought and cannot help but improve their stature. Whether such a program can be accepted depends on the conscience of the public and the desire of organized medicine to lead.

GUY OWENS '50
Chief of Neurosurgery
Roswell Park Memorial Institute
Buffalo, N. Y.

Harvard Women in Medicine

To the Editor:

I have read with various reactions the article, "Harvard Women in Medicine." The first time I read this article I felt happy in the knowledge that these women have successful home lives.

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We, who are graduates of Harvard Medical School, are experiencing what we hope to be the birth of the great Harvard Medical Center. It is my feeling that every doctor fortunate enough to graduate from this great institution must contribute something to the world in a medical way and this should be outstanding. With an average class of roughly 125, the investment in each of the careers is tremendous, and I now, as I did originally, ponder the advisability of using a definitive percentage of this great undertaking toward medical students who are so easily written off.

I have a very brilliant daughter of my own, who declares that she is going to Harvard Medical School and devote her life to pediatrics. I doubt the advisability of the great investment of her admission to Harvard, even if this were a remote possibility.

THOMAS WHEELDON, '18
Richmond, Virginia

We appreciate the esteem in which Dr. Wheelton holds Harvard Medical School even though this involves some cost to our women graduates.

Dorothy Murphy reminds us that a booklet, The First Decade of Women, was published in 1959, giving bibliographic material on the 83 women then holding the Harvard M.D. degree. Since 1959, the total has reached 102 out of some 5800 Alumni. Of this group, slightly under 10% of the women are now inactive in medicine. It is well to keep in mind, however, that this period of inactivity devoted to raising families may well be temporary, and that some of our male graduates defect permanently for other professions. Among our male alumni in other professions today, we count two college presidents, a senator, a banker, two lawyers, several ministers, a movie star, an orchestra leader, a realtor, writers, and business and pharmaceutical executives.

In addition, a small number leaves regularly for the various fields of public health. Since the men, in contrast to the women, are usually "lost" to the profession in later life, one would be obliged to compare our group of women graduates with an older group of men. Even so, we shall not know for several years how many women will return to medicine.

We at Harvard naturally feel that we select a high caliber of women with respect both to intelligence and dedication to the profession. It would not, therefore, be significant if we quoted statistics from other schools.

When all is said and done, it is too early to judge. We can only wait and see. — Ed.

Balancing Research with Teaching

To the Editor:

The Editorial by John Merrill in the Christmas issue is true. It seems a peculiarity of our time, however, to overlook some of the values of the past in viewing the accomplishments and success of the present.

I worked with the doctor in the painting by Sir Luke Fields. No, not the same man, but one like him. And I learned enormously about people.

I know that the doctor in the painting is not frustrated, nor does he consider himself in that household as a morale builder for the people there. He may be therapeutically impotent by our abilities today, but not by his in his day. In those days, an attack on symptomatology was about all the doctors had, all they knew, but frequently it worked.

Today we are prone to listen too little to the patient. We want to categorize promptly and initiate laboratory investigation that will solve the problem without ado. Sir William Osler, Francis Peabody and Henry Christian were investigators and clinical analysts of remarkable ability, but, those of us who were privileged to know a little about these men, know very well that each would return to his patient to see what the prescribed course of therapy was accomplishing. This in his way and in his time, to me at least, is what "The Doctor" did.

Listening to the patient and treating him as an unwell person must always be the *sine qua non* of the practice of medicine — even in all its diversifications.


WILLIAM T. WILKINS, JR. '23
Piqua, Ohio

To the Editor:

As you probably know, we are in the midst of an extended discussion in Richmond as to whether the Medical College of Virginia is devoting too much emphasis to research.

Your editorial in the Christmas, 1961 issue pretty well answers that question, and I am taking the liberty of sending my copy to the editor of the Richmond Times-Dispatch.

THOMAS WHEELDON '18
Richmond, Virginia



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HARVARD MEDICAL ALUMNI BULLETIN

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WINTER 1962

NO. 3

The Cover: After the storm — Looking toward Vanderbilt Hall from the promenade in front of Building E. Photo by David Lawlor.

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Along the Perimeter



Hugh Stubbins of trans-riparian Cambridge and Harvard has been chosen to design the new Francis A. Countway Library of Medicine. Conspicuous among Mr. Stubbins' recent designs are the Berlin Congress Hall (below), and the Harvard Loeb Drama Center in Cambridge (above). Work on preliminary plans is under way and prospects are good for ground breaking in the Spring of 1963.





Harvard Medical School? Guess again. The Boston Herald carried this front-page photograph on January 8 with the caption, "Pigeons retreat from huge puddles on the Common to higher ground." Although this balustrade and urn (in front of the Robert Shaw Civil War Memorial) are almost identical to those along our own promenades, they were designed by different men. Taken from a Roman balustrade, this design was the source of inspiration both for the Commons balustrade of Mr. Charles McKim and the Medical School balustrade of Mr. Henry Richardson Shepley. The latter designed the Harvard Medical School buildings at the beginning of this century.

Ernest MacLean

A New Division of Medical Biology at Harvard

A new Division of Medical Biology, designed to further the teaching of biologic science in its relation to human disease, will soon be inaugurated at Peter Bent Brigham Hospital here as an extension of the Harvard Medical School's Department of Medicine.

The new division will include in its faculty a group of biochemists, biomathematicians, and biophysicists headed by Dr. Bert L. Vallee, director of the Biophysics Research Laboratory, with a postdoctoral student body composed of practitioners, teachers, and investigators.

Through this new development it is hoped to provide "a new and orderly basis for the assessment and implementation of the objectives of medicine — to gain understanding of disease while simultaneously caring for the sick," according to Dr. George W. Thorn, Hersey Professor of the Theory and Practice of Physic at Harvard and Physician-in-Chief at Peter Bent Brigham. It is also intended to insure "a succession of outstandingly well-trained investigators."

Facilities of the recently opened 24-bed Clinical Research Center at Peter Bent Brigham, which is under Dr. Thorn's direction, will be used "to speed the application of new and basic medical knowledge to the care of patients."

Noting that a lack of integration between diagnosis of disease and treatment of patients gives rise to some of medicine's most serious problems, Dr. Thorn said the understanding of disease must be "based on human biology." Coordination of the new Division of Medical

Biology with the Clinical Research Center facilities is aimed at helping this process, he said.

New Acting Director at Children's

Greer Williams, Assistant Director for Public Relations and Development of The Children's Hospital Medical Center since 1960, has been appointed Acting Director of the Medical Center effective February 1. Mr. Williams will succeed Joseph P. Greer, Director, who will leave to take a similar position at the Children's Memorial Hospital in Chicago.

Mr. Williams, a former newspaper man, has been associated with medical science and medical organizations as a science editor and public relations consultant for the last 25 years. He came to The Children's Hospital from the Joint Commission on Mental Illness and Health, where he was editor of a five-year \$1,500,000 national mental health study that culminated in a final report, *Action for Mental Health*, published in 1961.

Before coming to Boston in 1956, he was Public Relations Director of the American College of Surgeons in Chicago, and was closely identified with the organization's public campaign against surgical fee-splitting and unjustified surgery.

Mr. Williams has served a variety of health and medical organizations as consultant, including the National Research Council, American Cancer Society, Veterans Administration. He is also the author of numerous medical publications for the layman. Two of his recent publications are the book, *Virus Hunters*, and the article, "Schizophrenics Can be Cured." The latter appeared in a recent issue of the *Atlantic Monthly*.



Inside HMS: Parable of the Stethoscope of Great Price

Recently, I went to see a psychiatrist. While some said that it was high time, a handful of others shook their heads sadly and asked, "Has it come to this?" It had begun when I bought a high-powered stethoscope advertised in the back pages of a glossy medical journal; the ad implied that grade-one murmurs were made to sound like steam escaping from a radiator valve. The device arrived by mail in a plain wrapper with an impressive surfeit of attachments. I spent several days trying all the various ear-pieces and auscultatory heads, one with another, seeking the optimal combination for each clinical situation I anticipated. By sheer good fortune, I stumbled upon the four-mm.-aperture earpieces and the sixteen-mm. bell, in conjunction with the thirty-five-mm. diaphragm: this combination elicited a murmur under almost any old circumstances, and ad-libbed a physiological third sound upon occasion.

To my dismay, however, I found that with the new instrument I also acquired a terrible ringing in my ears whenever I listened to a patient's heart. I soon discovered that, even without the stethoscope, the ringing persisted quite tintinnabularly. I kept asking patients if they had ringing in *their* ears, too, but they only smiled sympathetically, and kept on taking their phenylbutazone. In a burst of excitement, I dashed my new stethoscope to the earth, and ordered a monaural stethoscope from Laennec Apparatus Co., Ltd.

In the meanwhile I went to see an otolaryngologist who told me quite *frankly* that my problem was an inborn error of metabolism (particularly unstable benzene rings in my earwax were resonating at a peculiar frequency); I also sought out a psychiatrist. The latter told me quite *frankly* that the ringing was an hallucination, representing my unfulfilled childhood wish of becoming an electrician. He confessed to me that he often heard carillons chiming in his own ears, a product of his boyhood desire to become

a monk. "Monks have less atherosclerosis than electricians," he chortled gleefully, and gave me a reference.

I received notice that Customs officials were holding my monaural stethoscope for detailed examination: they wanted to apply a high duty to it as a musical instrument. I was forced to purchase a second-hand stethoscope from a first-year student, who had discarded it after a blood-pressure laboratory. The tubing was the wrong length and thickness, of course, and the auscultatory head (a Rube Goldberg affair) had evidently been designed by a fellow who had not the foggiest concept of cycles/second. I felt that I might be laughed off the wards, and I made fast the curtains about the patients' beds before I surreptitiously slipped my stethoscope from a brown paper wrapper I had concealed within my black bag.

With this primitive device, as you have anticipated, my ringing dissipated. I missed the grade-one murmurs, but at least I was through with the tinnitus. I eventually returned to my psychiatrist and spoke of my auscultatory failure. He told me quite *frankly*, in a most insightful manner, "You cannot make a silk purse from a sow's ear." Then he drew his cowl more tightly about his shoulders, and wandered off to the rectory.

PEPPER DAVIS '63



The Harvard Medical Society

The Harvard Medical School has not been able, as yet, to stamp out certain relativists who insist that medical education comes a full circle every seven years. The fact that our venerable Harvard Medical Society was regularly reported in the *Bulletin* until 1955 will only comfort the relativists, alas.

The "new" idea of reporting occasional meetings of the Harvard Medical Society Symposia in the *Bulletin* met with some enthusiasm from this year's Chairman, Dr. Albert Renold. "There are," he said, "few meetings that bring the School forward as a School. Of the Boston medical meetings, this is one of the better attended, although, in my ten years' association, I have noticed an unfortunate drop in the attendance of senior faculty members. It would be nice to have more."

There is also greater emphasis on interdepartmental symposia today, and the trend has turned away from departmental reports. "This is, in a way, regrettable," Dr. Renold said, "because it was interesting to review a whole department in an evening. So much research is in progress in each department, however, that a department head is hard put to single out three or four areas to report."

As has been the custom for several years, the Society's meetings are held in Amphitheatre D on the second

Tuesday of each month, from October through May. Each of the speakers is rigorously held to twenty minutes and the meeting closes promptly at 10 P.M. The Society devotes the last of its eight meetings to the competitive Undergraduate Assembly and presents the Soma Weiss Award to the student who delivers the best of four original research papers.

Founded in 1912 by Drs. Henry Christian and Harvey Cushing '95, the Society originally met fortnightly at the Brigham Hospital. The presentation of a patient was a regular feature of the early meetings; historical topics were also allowed, but since these meetings drew increasingly poor attendance, they were finally eliminated.

Three out of the four speakers at the January 9 meeting came from the new Stanley Cobb Laboratories for research in Psychiatry in the Warren Building of the Massachusetts General Hospital. Speakers were Dr. George Talland, Dr. Frank Ervin, Dr. Jack Mendelson and Dr. Marc Fried, under the chairmanship of Dr. Erich Lindemann. The variety of research studies was unusual for a single symposium.

Patients with intractable pain was the subject of Dr. Irvin's talk (studies conducted in collaboration with Dr. Vernon Mark). Pain, due primarily to cancer of the head and neck, was treated in 25 patients by electrodes stereotactically implanted in the sensory thalamus and left in place for days or weeks. Destruction of intralaminar nuclei by lesion, it was found, could produce pain relief without marked sensory loss. Lesions of the relay nuclei, however, produced marked loss of perception with no clinical pain relief.

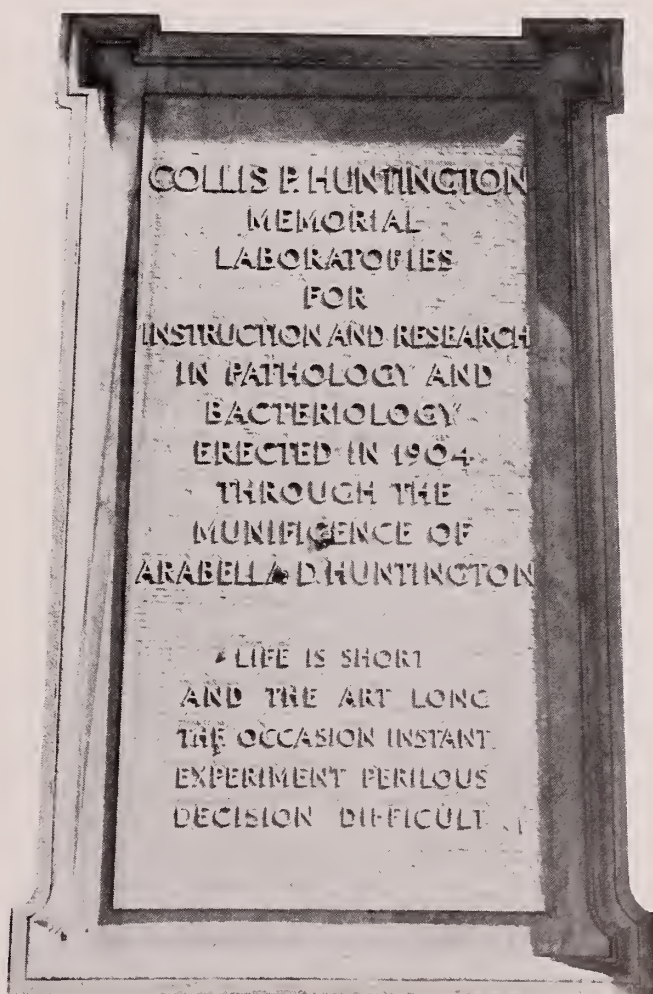
Studies of impairment in expectancy and memory were the subject of Dr. George Talland's talk, as he compared certain neurological diseases (among them Korsakoff's and Parkinson's syndromes) with the normal aging process. Disorders in memory, he reported, tend to be accompanied by diminished capacity to handle life's expectancies; in this respect, he noted a marked similarity between healthy men in their 70's and 80's and younger amnesic patients. The same changes, however, have not been observed in other conditions of deterioration. Reconstructing the past and constructing the future, he concluded, may therefore depend on the same brain mechanisms.

Dr. Marc Fried reported on patterns of personal and social adaptation among the lower-class groups of Boston's (now demolished) West End district. Social agency contact in this group, he reported, was strongly related to conflicts over cultural identity and status. Medical contact, however, in contrast to social contact, showed a pattern in which problems in the marital situation and family life were most prominent. Those alumni who remember Boston's colorful West End and have seen the new apartment complex rise next to the MGH with a rapidity to jar the psyche will be interested in the future findings of Dr. Fried's five-year investigation of "the impact of forced relocation from Boston's West End."

The purpose of experiments reported by Dr. Jack Mendelson was to study the effects of deafferentation on the electrophysiological activities, synthesis and utilization of ATP in cat brain. The broader issue of such a study relates to the correlation between electrical and biochemical activities of the central nervous system. Studies with deafferented preparations have shown that such a correlation does exist. Unexpectedly, these studies have also shown that an important relationship exists between certain chemical activities at point loci of both cerebral hemispheres and that intervention involving one hemisphere frequently is reflected in significant changes in the other hemisphere.

With something added to man's knowledge of brains in general, the January 9 meeting of the Harvard Medical Society closed (a few minutes after ten, to be sure), leaving the audience to bundle up their brains and set forth on a purely empirical study in the frosty night.

At the bottom of this tablet on Building D is inscribed the quintet of Hippocratic epigrams forming the first part of Hippocrates' first aphorism. Davis Ennis '36 sent a copy of this portion of the tablet to every member of his class.



Varaztad H. Kazanjian:

"Miracle Man of the Western Front"

WHEN Varaztad H. Kazanjian '21 was presented with the Special Award of the American Society of Plastic and Reconstructive Surgery, he rose to acknowledge the tribute with these words:

If my mother were here, bless her, she would believe every word of what you have said and would treasure them in her heart. If my wife were here, she would be pleased, but not entirely convinced. If my daughter were here, she would say, "O phew!"

Dr. Kazanjian wastes no time on himself. "I don't want to talk about a boy who came over from Armenia," he says. "Talk about what's happening in plastic and reconstructive surgery today." This desire to "get on with things" has brought Dr. Kazanjian a long way.

Born in Turkish Armenia in 1879, Dr. Kazanjian spent his boyhood in a period of Turkish oppression of Armenians, and when he was 16, he fled to the United States. "It was a very small ship and I was very sick," he recalls. "I arrived at Ellis Island with nothing but a small suitcase. You didn't even need a passport in those days." Since his only contact was an Armenian in Worcester he settled there and got a job drawing wire in a wire factory. Although he had been well educated in the French, Turkish and Armenian languages, and in mathematics and sciences in church schools in Armenia, he spoke no English. To master English he attended night school in Worcester and took correspondence courses.

One day, while bicycling with friends, the topic of dentistry came up. The idea of becoming a dentist stuck with Dr. Kazanjian because, as he said, "I always enjoyed working with my hands." In 1902 he passed the entrance examinations to the Harvard Dental School and became a member of the class of 1905. His record won him appointment after graduation as assistant in prosthetic dentistry at Harvard.

Since no hospital facilities existed at the turn of the century for the treatment of maxillofacial injuries and abnormalities of the face and jaws, patients were sent to the dental clinic. It was here that Dr. Kazanjian became interested in the treatment of fractured jaws and restoration of facial abnormalities. During those early years he treated hundreds of jaw fractures, and was one of the first Americans to discard the clumsy interdental splint and to substitute intermaxillary wiring. He smiles over the comment aroused when he treated a sailor who had lost his entire upper jaw in an accident. Dr. Kazanjian was asked to make a denture for the sailor, an almost impossible undertaking at the time. It took Dr. Kazanjian six months to devise an apparatus leading to the upper part

of the face, which was held in place by rods and wires. He remembers his pride in this accomplishment but also his embarrassment when Ripley heard about the "invention" and reported: "Believe it or not — Dr. Kazanjian made a man chew with his eyebrows!"

UNTIL World War I plastic surgery had concerned itself mainly with surface deformities. The outbreak of the war brought new types of maxillofacial injuries, not only flesh injuries but also fractures of the facial bones. In order to aid the British, in 1915 Harvard organized and sent overseas the first Harvard medical unit, intending that unit should remain only three months. Dr. Kazanjian was in charge of its dental service. At Camiers, he founded the first British army center in France, to cope with brutal facial injuries. This new center was soon overwhelmed with maxillofacial cases because, as he says, "nobody knew what to do with them." The main concern up to this time, Dr. Kazanjian recalls, had been the struggle merely to keep these patients alive. He extended treatment to the repair of disfigurement. His knowledge of dentistry proved invaluable in the development of new methods to reduce fatalities and restore hope to men who had been hopeless.

At the request of the British War Office the unit remained four years. As word of his operating skill spread, Dr. Kazanjian became a legend in the Allied armies. "The miracle man of the Western Front" was the way one British reporter described him. British medical experts began to converge on General Hospital No. 20 where they watched his surgical techniques and returned to their units to organize similar services in other locations.

Reluctant to let Dr. Kazanjian go, the English made hospital facilities available to him with assistants of his own choosing. The Harvard dental unit of the British Expeditionary Forces in France functioned under Dr. Kazanjian at the request of the British War Office until February, 1919. During that time, more than 3000 cases of gunshot, shrapnel and other severe wounds of the face and jaws passed through his capable hands and his services earned him investiture as Companion of St. Michael and St. George by King George V.

On his return to this country in 1919, Dr. Kazanjian realized he would need further training and a medical degree if he were to continue the surgery he had begun in France. That fall he entered the class of 1921 at Harvard Medical School. His classmates well remember the day two officers from the Royal Army Medical Corps lectured before Dr. Harvey Cushing's surgical clinic. One of the visitors recognized Dr. Kazanjian in the back of the room and dragged the embarrassed student to the floor to introduce him as the man who had taught them the technique they were about to demonstrate.

While still a student at Harvard Medical School, Dr. Kazanjian was Professor of Military Oral Surgery at Harvard Dental School. He was Professor of Clinical

Oral Surgery at Harvard from 1922 until 1941, when he became Professor of Plastic Surgery. He became Professor, *Emeritus*, in 1947. As a teacher at Harvard for more than forty years, Dr. Kazanjian observes that he always sought to impress upon his dental students the medical aspects of a dental practice and at the same time to show medical students the manner in which dental knowledge and techniques can be applied to the field of maxillofacial surgery.

For years Dr. Kazanjian also headed a clinic for plastic and reconstructive surgery at the Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital and Mount Auburn Hospital.

Reminiscing, Dr. Kazanjian said, "When I was a student, we used to see such things as cleft palates in children and adults. At that time prosthetic appliances were preferable to surgery because surgery wasn't advanced enough, yet many of the patients with prosthetic devices could talk as well if not better than those who had had surgery." Although surgery has largely taken over the treatment of facial deformities, prosthesis, he feels, is still very effective when surgery fails to complete repair. "There can be no doubt," he comments further, "that dentistry can contribute a great deal, especially in the surgical treatment of face and jaw deformities."

The major concern of Dr. Kazanjian's career — the recognition of plastic and reconstructive surgery in its own right — is now largely a reality. Looking forward to the future, he mused recently, "Progress in plastic surgery? New methods must always be found to handle old problems, or to handle the new problems which we bring upon ourselves. Who, for instance, would have foreseen psychiatry's important role in the treatment of plastic surgery patients?"

SUCH a quiet and unassuming surgeon is difficult to characterize. The more warranted the eulogy, the less comfortably it rests upon the man. Yet anyone who has met Dr. Kazanjian will feel his old-world quiet naturalness. In the words of his colleague, Dr. Robert Ivy, "In 32 years . . . I have never known him to criticize harshly the work of others, a characteristic belonging to few of us." Or again, "While many of us, his contemporaries, are now laid on the shelf, at least in part, he is still in great demand as a teacher." Not only is he in demand as a teacher, but also as a surgeon. He still maintains an active practice, and commutes daily from his Belmont home to Boston hospitals and to his office on Commonwealth Avenue.

At the New Hampshire farm near Lake Sunapee where Dr. Kazanjian spends his vacations, he and his wife are usually surrounded by his children and grandchildren. One of his special joys is the fact that his daughter, Joan K. Hiatt, is carrying on the family medical tradition as a pediatrician in Altus, Okla. Dr. Kazanjian is known as a robust swimmer and a devoted



Dr. Kazanjian

fisherman, "even when the fish don't bite." In New Hampshire, Dr. Kazanjian, who calls himself a "clumsy gardener," tramps the woods for wildflowers. Anyone who has seen the profusion of delicate wildflowers that he has transplanted around his home will doubt the prefix, "clumsy."

One hobby of which Dr. Kazanjian is proud, however, is the "library" of plaster busts of many of his most unusual World War I cases. This collection, showing facial wounds before and after reconstruction, is now a part of Harvard Medical School's Warren Museum collection.

Among Dr. Kazanjian's many contributions to the literature of his specialty is his volume, "The Surgical Treatment of Facial Injuries," written with Dr. John M. Converse and considered to be the definitive work in this field. He has also published numerous papers dealing with plastic and reconstructive surgery.

"The members of my generation," wrote his fellow plastic surgeon, Dr. Bradford Cannon '33, "who have had the privilege of association with Dr. Kazanjian, are constantly impressed with his accomplishments and his original approach to surgical problems. To the untrained observer there is an air of mystery about his work. To the trained observer his methods are based on sound principles of reconstructive surgery. His place in American plastic surgery is the result of a lifetime of careful, thorough, industrious effort combined with a remarkable ability to select the best from his background in both dentistry and medicine."

The *Journal* Celebrates

The hundred and fiftieth anniversary of the *Journal*, initiated by a special number appearing on January 4, 1962, reached its climax nine days later with a dinner at the Harvard Club of Boston. Approximately 300 guests attended the function, which was presided over by Dr. Richard M. Smith, chairman of the Committee on Publications, who introduced Dr. David W. Wallwork, president of the Massachusetts Medical Society, as toastmaster.

"All those present," the *Journal* insisted in a recent issue, "were impressed by congratulatory messages from President Kennedy and Governor Volpe and by the introduction of distinguished guests, the most notable being Dr. Elliott P. Joslin, the Society's alert and active non-agenarian fellow." (Dr. Joslin died suddenly on January 28. See page 38.) Dr. Wilder G. Penfield, of Montreal, eminent neurosurgeon and writer, now honorary consultant to the Montreal Neurological Institute, spoke on "The Serpent and the Quill." Dr. Joseph Garland, Editor of the *New England Journal*, cloaked his very amusing talk with the innocuous title, "Remarks on Sesquicentennialism."

"The *Journal's* first hundred years," the *Journal* commented on itself in an editorial, "were probably the hardest, but the next fifty were no sinecure, although the blows of 48 of them were softened by the backing, and the last 41 by the actual proprietorship, of the Massachusetts Medical Society.

"It is confidently expected that even if the affairs of mankind run a reasonably normal course (they never have), in another 50 years the *Journal* will be in the midst of or just recovering from its bicentennial observance."

The Joe Vincent Meigs Professorship of Gynecology

The announcement of five new professorships in the last issue of the *Bulletin* hardly overshadows our latest endowment, the Joe Vincent Meigs Professorship of Gynecology. Since 1955, shortly after Dr. Meigs retired from a cluster of titles at Harvard and the Massachusetts General Hospital, a campaign has been in progress to establish a professorship in his name.

In addition to his years of service as professor of gynecology at HMS and as chief of the gynecological service at the MGH, Dr. Meigs was chief of staff of the Vincent Memorial Hospital, a small hospital with rather colorful beginnings. Now part of the Massachusetts General Hospital, the Vincent Memorial was founded independently in 1892 for diseases of women.

Established as a memorial to the late Mrs. J. R. Vincent, beloved actress of the Boston "Museum" Stock Company, the hospital received support from theatrical performances of such actors as Edwin Booth and Edward A. Sothorn. In recent years, it has received much of its

support from the annual Vincent Club Show. In 1940, the Vincent Memorial Hospital became the gynecological unit of the MGH and Dr. Meigs, a visiting surgeon at the MGH since 1938, became the chief of its gynecological service in 1941. The following year he was appointed clinical professor of gynecology at Harvard Medical School. As a surgeon and a very public-spirited member of the profession, Dr. Meigs has contributed continuously to knowledge about the treatment of cancer of the female organs.

Under the terms of the agreement by Harvard, the new Meigs chair will be held by the chief of staff of the Vincent Memorial Hospital. Dr. Howard Ulfelder is the first incumbent of the Joe Vincent Meigs chair in gynecology.

"The Meigs Professor," said Dr. George P. Berry, at the outset of the campaign, "will be a leader in that field of human biology that concerns man's own beginnings, his embryonic and fetal growth, his development into an adult male or female. At Harvard he will be able to draw on a fellowship of scholars representing every discipline to help him create a new and more vital kind of gynecology."

Thomas H. Lanman Memorial Scholarship

Honoring Dr. Thomas H. Lanman '16, the first director of alumni relations of the Harvard Medical School and a beloved member of the Faculty of Medicine, the Harvard Medical Alumni Association has provided the capital funds needed for the establishment of the Thomas Hinckley Lanman Memorial Scholarship Fund at the Medical School. Dr. Lanman died on Saturday, March 25, 1961, at his home, 95 Suffolk Road, Chestnut Hill, Massachusetts.

The gift from the Medical Alumni Association to Harvard Medical School has been made possible by contributions in memory of Dr. Lanman from friends, colleagues, and alumni from all parts of the country. The gift will provide an annual scholarship for an outstanding medical student requiring financial assistance. The first award of the scholarship will be made next spring.

"Alumni activity at the Harvard Medical School was comfortably at rest when Dr. Lanman became Director of Alumni Relations in 1951," said Dr. Samuel A. Levine, President of the Harvard Medical Alumni Association. "From this position of comfortable inactivity, he labored diligently to infuse the members of the Alumni Association with an awareness of their responsibility to the Harvard Medical School, and — through the Medical School — to contribute to the future strength of American medicine. The Harvard medical alumni responded to his challenge and now the Medical School has what is widely considered to be the most successful medical alumni fund in the nation. This was no easy task. For Dr. Lanman's tremendous contributions, all of us are deeply indebted to him."

GHANA



LAND OF PROMISE AND UNCERTAINTY

Charlotte G. Neumann '56, S.P.H. '60

Alfred K. Neumann M.D., S.P.H. '60

AS we approached Accra by jet, we saw a broad expanse of blue ocean and gleaming white breakers moving toward wide beaches as far as the eye could see. Next came a narrow band of palm trees and, beyond that, a belt of grassy plain with few trees. Farther to the north, low dark hills were just barely visible, but there was no jungle anywhere in sight.

Accra, from the air, is a big sprawling city dotted with islands of new, modern buildings. One could see many gashes in the ubiquitous red laterite earth where new construction was in progress. Along one side of the airport stood a row of strange looking Russian Ilyushin jets belonging to the Ghana National Airways.

Our friend, Dr. Sai, who was our classmate at the HSPH and now is deputy chief medical officer of Ghana, was at the airport to meet us. The first thing we noticed was that here in Ghana, unlike the other West African countries where we landed, everybody seemed to be smiling and happy. This impression has been confirmed by many others, and is perhaps a reflection of a more prosperous country and a higher standard of living.

For some years prior to our graduation from the Harvard School of Public Health in 1960, we had vague plans of working in one of the developing areas of the world. We were eager to go when, in the Spring of 1961, we were invited to go to Ghana for several months of intensive training and research in tropical medicine and public health under the auspices of a new Harvard-U.S. Public Health Service training program. Our one-year-old son, Frederick Kofi, accompanied us. "Kofi" is Ghanaian for "son born on Friday." Both this name, and our interest in Ghana had already been stimulated here, through our Ghanaian friends, the F. T. Sais. Dr. Sai is now Deputy Chief Medical Officer of Ghana.

MARKET MAMMIES — CAPITALISTS PAR EXCELLENCE

As we drove from the airport through Accra to the Korle Bu Hospital resthouse, we followed a dual highway flanked by familiar Mobil and Shell stations, past stately homes with formal gardens, which gave way to ever more humble dwellings until we reached an older district of ramshackle, corrugated metal-roofed structures squeezed one upon another. Along the roadside, vendors sold everything from fruit to lottery tickets and tooth paste. These were the powerful "market mammies" of Ghana, their babies tied to their backs with black woolly heads and two big eyes peering out. These women had eliminated the need for baby sitters. But this was not their most remarkable feature. In the hands of these market mammies, we were soon to learn, lies the bulk of the nation's small business enterprise. As a group, they are so powerful, that they in large measure control food and fuel prices. Accra Fishermen have been known to dump their catches overboard, rather than submit to the mammies' price fixing. By obtaining their merchandise at the big European wholesale or retail houses where poor Ghanaians infrequently trade, they are able to sell in the street markets at a good markup. They usually carry their profits with them or hide them at home. But little mammy money finds its way into the banks and the latter are thus denied a sizeable capital for investment. The mammies are also a real political force to reckon with. The rebuilding of a notorious slum in Accra, for instance, has never been carried out, although the plans have been drawn up and money set aside for years. The slum happens to be the site of a very active mammy market, and the mammies refuse to allow any razing. These women begin to learn in childhood. We saw many young girls already bargaining with trays on their heads containing a few items for sale. This

A northern bush village with typical round huts.



Cocoa Marketing Board Building on Kwame Nkrumah Boulevard in Accra.



forceful, independent, relatively wealthy, and politically powerful group of women is a most potent argument against Ghana's going Communist.

Our spacious resthouse by the sea was furnished with hand-polished mahogany pieces, the "ordinary" wood in a country where mahogany is plentiful. The absence of a kitchen caused some consternation, but the problem was solved when Ali Kadjo appeared. He was a combined houseboy, cook, laundromat, and temporary baby sitter. He presided over the kitchen which was located in another building across the courtyard.

We became very fond of Ghanaian food. On this particular day the menu included chicken and groundnut (peanut) stew with tomatoes which was served with cooked, pounded yam and plaintain "fu fu." This was followed by salad and steamed fresh sea bass. We concluded this first of many delicious Ghanaian meals with fresh native pineapple, sweeter and paler than our Hawaiian fruit. We might add that we later shopped in the open markets and bought food just off the fire in roadside stalls. We consumed these foods with relish and never had any ill effects. Furthermore, Frederick's milk while in Accra was made with unboiled water and he thrived all summer.

THE GHANA HEALTH SCENE

The focal point of our professional life was the Ghana Ministry of Health which was in charge of all phases of public health and clinical services. One sensed a spirit of urgency present at the deliberations of the senior staff. A rising tide of expectations must be met. A parliamentary mandate to span the country with modern, Western-type medical facilities, staffed with well-qualified physicians, is being carried out as rapidly as possible by recruiting physicians from all parts of the world and offering them attractive contracts. The health planning process takes on dimensions one rarely, if ever, considers in this country. Is it more efficient to build a clinic in area "X" or could good services be provided for the area by constructing connecting roads from the region to the nearest district hospital? Successful malaria control in the Eastern region requires not only assistance from international agencies but cooperative agreements with bordering countries. Up to now, this cooperation has not been forthcoming. Thus, other ministries and the diplomatic service are becoming involved.

It is necessary, not only to expand preventive services, but to re-educate the people in matters of nutrition, basic sanitation, and use of medical facilities. At the present, Ghanaians still spend large sums on traditional "ju-ju" medicine man cures and patent medicines. This means that patients frequently do not arrive at the hospital until they are hopelessly ill, and the hospital is subsequently branded as a place to die. Ghana is not unique in its problems of coordinating community development efforts with those of education or in its difficulties in resisting

the lure of sophisticated research and treatment facilities. Prestige and politics are powerful influences in determining program development. This problem is not peculiar to Ghana alone; it extends to most of the new nations of Africa.

And always, there is the avalanche of the acutely ill who must somehow be helped immediately. The multitudes begin to line up at the hospitals at dawn. The pity is that the supply of Ghanaian and foreign physicians, in spite of a constant stream of new recruits, is stretched so thin that physicians have barely time and energy to deal with illness already present.

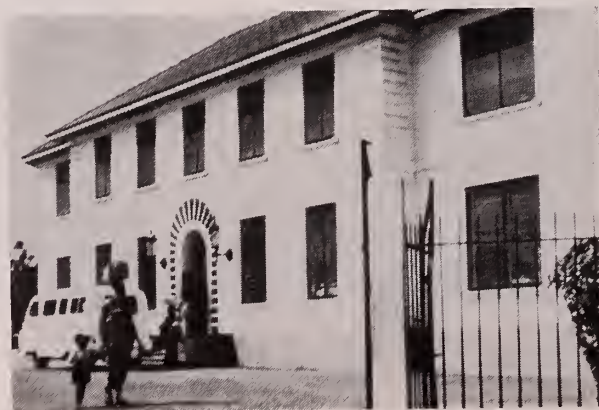
Unfortunately, there is as yet no medical school in Accra. Although the money to build the school is available, no U.S. school has seen fit to provide faculty members to staff a medical school for Ghana. There are of course extenuating circumstances: the Ghanaians, for instance, place a great deal of emphasis upon rank. It is questionable if they would accept dept. heads of lower than professorship status. Yet few, if any, U.S. medical schools could meet such a demand. Add to these difficulties charged political climate and it is easy to see how complex is the evaluation of the medical school question.

Can a nation prosper unless the vast majority of its people are adequately fed and are reasonably free of disease and disability? Obviously, a balance must be reached between immediately productive investments and investment in human resources which will yield longer range returns. As a partial solution to the problems, the Ministry of Health has attempted to attract outside resources, material as well as human. Much of the technical, expert personnel has come from Israel and the U.K., and financial support has been welcomed from both East and West.

And so, we found, gathered on the Ghana health scene, a stimulating international group. In no place is

Blood-letting at dawn in Patikro.





Princess Marie-Louise Children's Hospital for nutritional disorders in Accra.

*Three toddlers
waiting to have
blood drawn.*



*A well-nourished
baby. Mother is
still breast-feed-
ing this child.*



*Housecall in Patikro. Young
Ghanaian boy with malaria
chills (wrapped in shawl)
huddles close to stove.*



*Bringing home the
coco yams, an
important staple.*





Ghanaian grandmother preparing akasa (corn gruel) for weaned grandchild who is bound to her back in traditional style.

this cosmopolitan cooperation better exemplified than at the Korle Bu General Hospital in Accra. Korle Bu is an extensive establishment of about 500 beds. It is the main teaching hospital of the country and boasts a staff of excellent physicians including many U.K. trained Ghanaians who are outstanding by any standard. Our role was to take part in rounds on both adult and children's wards, examine patients, participate in teaching conferences, and to study parasitology in their well-run laboratory. We spent much time, also, in the much smaller Princess Marie Louise Children's Hospital, a facility of some forty beds with a very active clinic attended by 150 to 400 children per day. This hospital is devoted primarily to the diagnosis and management of nutritional disorders. Here we had the opportunity to pursue our interest in nutritional diseases and to care for these patients.

Not all of the children admitted to the PML who had developed kwashiorkor or marasmus were poor. Some came from relatively wealthy homes. In many cases, ignorance, folk customs and taboos played a role in determining the poor feeding practices. An impressive attempt at parent education was in progress. One of the conditions of admitting a child was that an adult member of its family, preferably the mother, live in the hospital with the child and participate in its nursing care. This included feeding the child under supervision, with food prepared by the dietitian. This diet consisted entirely of locally available foodstuffs which are within the means of all but the most destitute. Also, the family member was required to attend daily nutrition classes held in an open-air classroom in the hospital courtyard, along with mothers of children seen in the OPD who are directed to these classes in an attempt to forestall admission of their children. Results were encouraging with these educational endeavors.

The most significant health problems that we encountered throughout the summer were malnutrition (protein and caloric), falciparum malaria with a wide spectrum of clinical manifestations, gastroenteritis with dehydration, typhoid fever, sickle cell and nutritional anemias, tuberculosis, respiratory infections, and the after-effects of polio. Among the toddler age group we were particularly impressed by the gravity of measles, which is endemic throughout the year. In this poorly nourished group measles often produces severe pulmonary complications and precipitates acute, fulminating kwashiorkor. Most striking to us, however, was the realization that almost every condition was preventable through improved basic sanitation, malaria control, and better nutrition.

WORK IN A FOREST VILLAGE

One phase of a modest nutrition and hematology research project took us into one of the more isolated forest villages. The project had been initiated in Accra on young children with protein-poor diets or with overt

kwashiorkor. Our purpose was to try and correlate quantitative dietary intake data with biochemical and hematological data. We needed a relatively isolated agricultural village in which the diet was notably deficient in protein. Such a village was Patikro in the non-cocoa-producing area of the Ashanti Forest about 200 miles northwest of Accra with some 400 residents. This is a village of sunbaked, thatched mud huts arranged in clusters around quadrangles with an extended family group occupying such a unit. The streets of packed dirt were clean swept and wide with a fetish temple and sacred "juju" tree dominating the main street. Adjacent to the village were the farms of the chief and elders, and beyond that the fields tilled by the rest of the villagers. The primary staple of the diet was cassava, a starchy root, and plantain, a large non-sweet banana. Their protein content is less than one per cent. A taboo exists against eating beef. Pork, for practical purposes, was nonexistent. There was also a strong feeling against feeding children eggs, lest they become thieves. The available fowl, sheep and goats were reserved for sacrificial occasions and children received little, if any, of this meat. Wild game for some reason was practically absent. Weaned children received only starchy gruels and now and then bits of smoked fish which found their way into the family stew.

We were very well received in this village and were impressed by the universal cooperation, dignity and the wisdom of the chief and elders, despite the fact that they had never heard of the United States, nor of

Little Frederick Kofi Neumann and Mama, with Ali Kadjo, houseboy, at home in Accra.



Harvard! On a preliminary visit, we had been very careful to point out to the chief and his council of elders that our investigation would bring no immediate benefits to the village, but that we hoped that our efforts would result in creating a better life for them at a future date. The chief, after duly conferring with his council, gravely told us that it was all right for us to go ahead, that they would all cooperate, and that even if they didn't benefit as long as their children or children's children might benefit, our efforts were welcome.

Drawing fasting bloods from toddlers with fragile veins at dawn in the village square with a fine mist falling, in the presence of some forty anxious onlookers, including the chief, was a somewhat unnerving experience.

When we had concluded our research activities, which included the freeze-drying of the freshly obtained plasma in the field for analysis in the U.S.A., we held a medical clinic for anyone from the village who cared to attend. One hundred and sixty-seven men, women and children came.

Sadly we realized that our clinic was a small gesture despite the large quantity of medicine we handed out. These people would have the identical complaints in no time unless some basic changes were made in their village. We were deeply touched by their tokens of appreciation: some dozen bush eggs and handwoven strips of Kente cloth from which the traditional Ghanaian togas are made.

IS GHANA GOING COMMUNIST?

This is the question put to us by many since our return. On the basis of our experience the answer is a firm "No"! Will Ghana continue to accept aid and technical assistance from behind the Iron and Bamboo curtains? Yes, we think, for a long time to come and in increasing amounts. Furthermore, we see no contradiction between the two statements. In the course of the summer we spoke to many Ghanaians of varied educational, social backgrounds and, for the most part, we found little interest and/or little knowledge of the non-African world. The two notable exceptions were nuclear testing and racial incidents in the United States. The dominant concern is to develop Africa generally, and Ghana in particular, as quickly as possible.

There seems to be little desire to align with either East or West. Rather, these power blocks are each regarded as potential sources of aid. Nkrumah and Nkrumahism are by far the dominating political concerns and dwarf all other political influences. Even if Nkrumahism is replaced by another "ism," it is likely to be a Ghanaian, not a Soviet, variety.

There are technical assistance personnel from many countries in Ghana. Those who hold degrees from Great Britain or the United States and not the Moscow degree are most highly esteemed. Emotional and sentimental

ties with Britain are still extremely strong in Ghana. The Queen is very much revered, as was evident during her recent visit and on occasion, the Ghanaians are quite capable of "out-Britishing" the British.

The main opinion we heard about Russian efforts was one of mild ridicule. The Russian community tends to keep to itself and we were told that its members are homesick and are happy when they can return to Russia. Many of the Russian projects have been far from successful. The Western press recently expressed great concern over the fact that some 70 odd Ghanaian military cadets were sent to Russia for training. What was not generally mentioned was that several hundred full scholarships had been offered but not enough qualified Ghanaians could be found who wanted to go.

PROBLEMS

Financially speaking, Ghana is in a somewhat difficult position at the present time. To a great extent this accounts for the recently accelerated pace of wooing aid from any and all sources. At the time of her independence, Ghana had plentiful financial reserves and cocoa, her principal export, commanded good prices. Since then, a steady decline in the price of cocoa and an ever increasing demand for imports has produced a series of deficit budgets. The much discussed Volta River Dam project, which will probably be financed largely by the U.S., represents a move to increase production for export and to attract large amounts of foreign capital into the country. Increased import duties and purchase taxes on a wide range of goods (including items essential to the daily living of the poor) were imposed this past July, as another effort to improve the country's financial picture. The new taxes touched off strikes in some areas which were relatively widespread and protracted, although officially minimized by the highly controlled press.

In the realm of politics an important problem faced by Ghana as well as by other newly emerging countries is the issue of multi-party government versus a one-party system. Although a two-party government technically exists in Ghana, it is hardly a reality, in part at least due to the suppressive measures of the party in power. President Nkrumah justifies these measures with the argument that all energies are needed to achieve a self-sustained economic growth and that the country cannot financially support expensive strikes and political rivalries. In the short run this may be partially true, and the repressive measures when viewed in the light of traditional African tribal politics may not be nearly so harsh as when seen only from the perspective of contemporary Western politics. One cannot help but be disappointed, however, at the apparent drift away from the lofty ideals promulgated by those who were in power at the time of independence.

BOSTON ARTS Festival

George Shattuck Richardson '46

EVERY June since 1952 there has been in Boston, the Hub, the Athens of America, a strange and wonderful blossoming of fine and lively art in the Public Garden. For a little over two weeks, an average of 45,000 non-paying guests stroll each day through tents housing 500 paintings selected from some 1,500 submissions. In spite of heat or rain, the lines form hours before performances which feature such artists as Robert Frost, Carl Sandburg, Archibald MacLeish, Marianne Moore, Martha Graham, André Eglevsky, Mia Slavenska, Maria Tallchief, José Limon, and Melissa Hayden — to name but a few who join the spirit of the Festival in spite of meager financial reward.

We all know how a city suffers from central necrosis, with ischemia most marked in the summer. The excite-

ment and interest generated by this annual festival provides extremely effective therapy. And, of course, the Festival is enormously important to the artist in this patronless age. From the relatively secure world of medicine, it is difficult to imagine the risks involved in being an artist; but it is easy to understand that, if an artist is to gain recognition for some new vision, his vision must be seen. The Festival provides the artist with the opportunity to show and the public with the opportunity to see, though not necessarily to perceive, such visions.

Who pays for the Festival? Surprisingly enough, private sources, along with the business community and the musicians' union, provide a full 93 percent of the \$150,000.00 annual budget. The City foots the bill for a mere 7 percent of the total.



"Is art for instruction, or is it for delight?"

Is art designed to instruct, or should it delight? This was a question long debated in the culture of Greece and Rome, and the ancients bequeathed us no solution. Should an arts festival uplift, or should it be fun? Is there such a thing as immoral art? Plato thought so, and so did Hitler and Stalin. And how does one evaluate *new* art? From the Renaissance, we have inherited the unresolved quarrel of the Ancients and the Moderns. You remember the slogan: "Imitate the ancients" (in contemporary terms: "Be a conformist"). But there are a good many more "ancients" today than there were in Renaissance times. It is not so difficult to judge imitation Vermeer or imitation Mozart; one has only to compare original Vermeer or Mozart with the imitation. What, then, must one do when everyone in Boston seems to say in June: "How about this new stuff? Why can't they paint like Grandma Moses used to paint?"

These problems become specific and acute when 500 paintings must be selected from the 1,500, and even before this, when the committee qualified to make the selection is appointed. What is a painting? Is it a two-dimensional design in a quadrilateral space; is it a picture of an object or objects which follows, as does the camera, certain optical conventions; or, is it, as Wordsworth termed a poem, "an emotion recollected in tranquillity"? Actually, a painting is all of these things, and more, and you may be assured that every definition has its vociferous adherents, and may constitute, as does abstract expressionism for instance, a school.

It is, in the mind of this writer, an error to divide all art into abstract art on the one hand and representational art on the other. Surrealism, for example, is neither abstract nor representational. Surrealist paintings are like pictures of dreams. Dreams probably can be abstracted as well as represented, but it would be difficult in a given instance to decide which was being done. The art of Islam is almost entirely non-representational — but is it abstract? In medicine, we are familiar with a great variety of semi-abstract ways of looking at things (cross-sections, camera-lucida drawings, exploded views) as well as the larger number of completely abstract representations familiar to the scientist, such as graphs and metabolic charts; today, we have, in addition, an increasing number of unusual views of reality made possible by scientific instruments such as the electron microscope. We physicians are perhaps more aware than many professions that it is not that little optical instrument, the eye, which sees, but the brain, and that the brain may choose whatever optical instruments it desires and in-

terpret our data in many ways, even with admixtures of emotion. (That we are a uniquely receptive group in the matter of art is quite conclusively proven by the artistic character of the advertising brochures with which the drug companies bombard us!) We know, then, by direct experience, that abstract and representational art do not belong in mutually exclusive categories. They are, nevertheless, inflammatory terms today, and it will be difficult in 1962 not to be forced into using them despite one's better judgment.

AT the present writing, the Boston Arts Festival for 1962 is still on the drawing-board, after a tremendous artistic success in 1961 which failed financially because of high costs in the performing arts. The administration consists of a president and an executive committee of public-spirited citizens. This administrative group has the task of working out the Festival program with the executive director, a position filled this year by Mrs. Alison Ridley Evans. Hers is the artistic role, ours the administrative. One may ask how a surgeon can participate in such activity at all. The answer is that surgeons participate in many such things in their communities as consumers, and it seems fair in return to participate on the production end in this relatively small way. And, after all, some surgeons are, unlike this writer, themselves artists.

The Public Garden lends a backdrop of ponds, swan-boats, to the gay tents. People here are excited about art. The Festival is an issue, and it has us all debating like citizens of ancient Greece or Renaissance Italy. What will it be this year — Beatnik or Proper Bostonian?

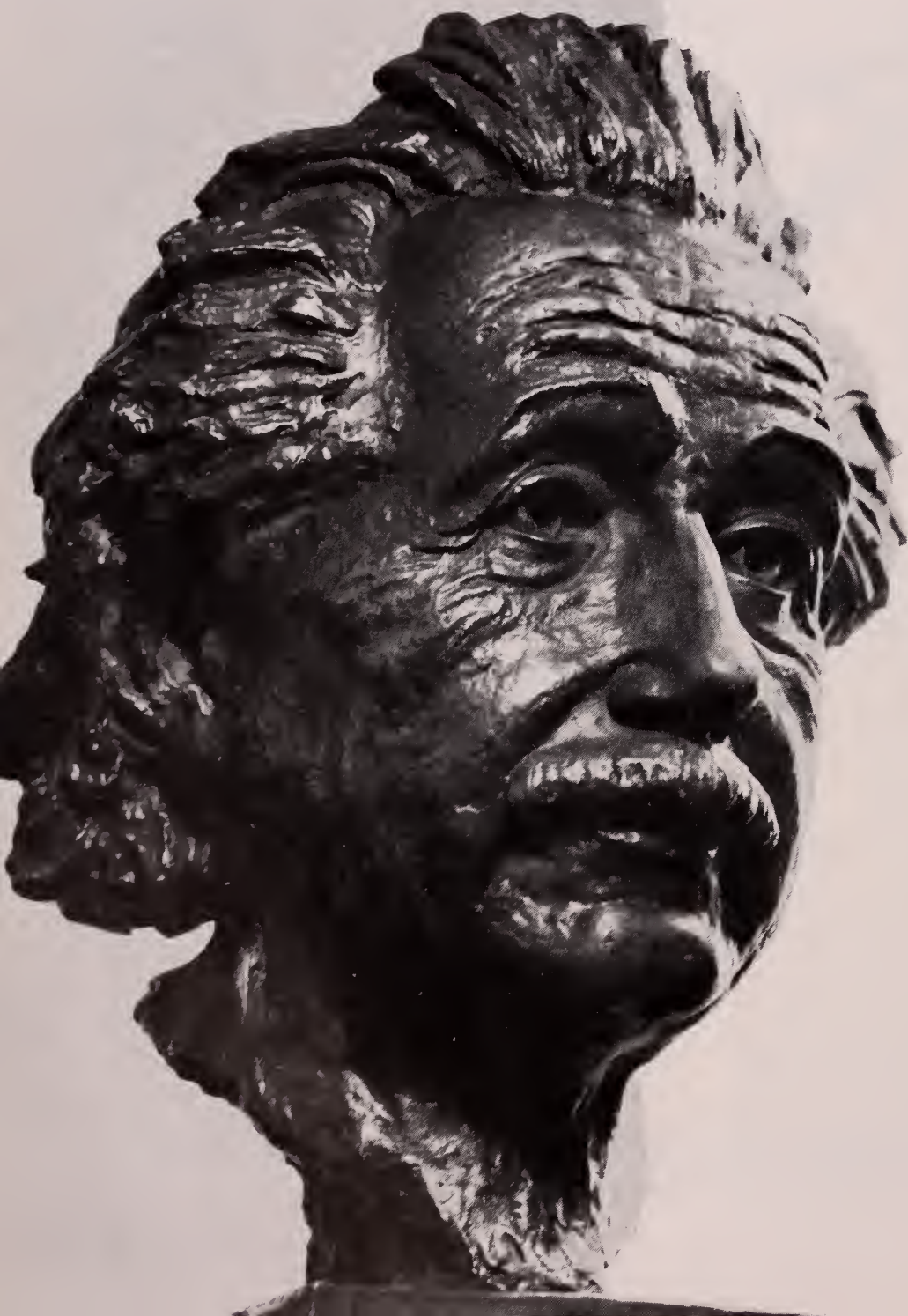
This year, Dr. Richardson is President of the Boston Arts Festival. Of our School's role in the humanities, he feels there is a need "to emphasize humanities a little as well as science."

In addition to his duties as Assistant in Surgery at the Massachusetts General Hospital and Clinical Assistant in Surgery at HMS, Dr. Richardson is engaged in gynecological research on ovarian steroid biosynthesis and cancer chemotherapy.

Mr. Al Capp, who has provided the art work for this article, is a Trustee of the Arts Festival. Readers of his strip will know that the Festival has already been featured in the annals of Li'l Abner.

The

ALBERT EINSTEIN



COLLEGE OF MEDICINE:

A MODERN MIRACLE

HISTORICAL BACKGROUND

Yeshiva University was founded some 75 years ago as a rabbinical college. Forty years later it established, in addition, a College of Arts and Sciences, and about fifteen years ago it achieved University status. A Medical College was therefore a logical next step. Today, in 1962, the Albert Einstein College of Medicine is about to graduate its fourth class.

Until the founding of Yeshiva, Jewish citizens, while contributing to existing schools and universities, had no schools of their own, except for parochial institutions. Perhaps this is understandable in the light of their history. For centuries, learning, to Jews, meant the study of the Bible. Traditional support of schools or colleges meant support of religious schools and rabbinical colleges. Thus, up through the Age of Enlightenment in the 18th Century, and for at least 100 years more in Eastern Europe, the most ardent wish of a Jewish parent was that at least one son in the family should become a rabbi, and if not an ordained rabbi, then a Biblical scholar. Indeed, my own father, whose five sons had for the most part tended from early life toward careers as artisans, recognized in me some interest in learning, and he fervently hoped that I might become a rabbi.

In modern times and free societies, Jewish boys and girls turned from religious learning to secular fields. Their parents at first fought the trend but eventually permitted them to do so, while at the same time continuing to devote their own major support to the rabbinical colleges.

As Biblical scholarship became less and less a prestige symbol in Jewish life, and the rabbinate became

Of his many rewarding experiences, Dr. Leo M. Davidoff, neurosurgeon, rates association with the Albert Einstein College of Medicine high on the list. One of its founders and newly appointed Associate Dean of this new Medical School, he had for many years been a Professor at Columbia University's College of Physicians and Surgeons. He has also gone on many teaching missions abroad and has consistently combined teaching, practice, and research.

Leo M. Davidoff '22

Professor Einstein and the author, at the time of the naming of the Albert Einstein College of Medicine.



even more limited in its appeal as a career, the flow of philanthropic funds from Jewish contributors was diverted in ever larger measure to hospitals and eleemosynary institutions. Indeed, when Yeshiva University established a College of Arts and Sciences near the end of the 19th Century, it was the first secular institution of higher learning in America under Jewish auspices. Brandeis University, founded in 1948, was the second.

As a matter of fact, the history of Yeshiva University's development paralleled in many respects that of the great universities in England and America. Most of them, such as Oxford, Cambridge, Harvard and Yale, began as colleges for the education of clergy, and then branched out into secular fields, eventually including schools of medicine. Yeshiva University's decision to found a medical school in 1951 marked the first time in 57 years that New York State had granted permission to build a new medical school.

One afternoon, I was called to a meeting of several senior staff physicians at one of the voluntary hospitals in New York City. Dr. Samuel Belkin, the President of Yeshiva University, disclosed the existence of his precious piece of paper, and asked the staff to consider offering the facilities of that hospital to this as yet nonexistent medical school.

I was made reflective and entranced by what I had learned that afternoon, and remained dreamily behind when the others had left. I felt a touch on my sleeve, and was recalled to reality by a small, determined figure. It was Dr. Belkin himself who stood beside me. "Well, Dr. Davidoff, it sounds like a big undertaking. Do you think we can do it?"

"I don't know," I answered him. "It depends on how much backing we can get, and on how far we are willing to go. What is your notion of the cost of such an undertaking?"

"I am not sure," he answered hesitantly, "but I think I can raise two, possibly three million dollars." I was shocked by his naïveté. I recalled that only a few weeks before I had learned that Columbia College of Physicians and Surgeons was having to dip into capital, in spite of a 40-million-dollar endowment, a completely paid-up modern plant and adequate hospital facilities for clinical teaching. When he then asked me, "What do you think it would cost?" I answered coolly that 50 million would do for a start. I felt that in order to build a new medical school, it must be built on a modern scale, with science buildings and hospitals in geographic proximity, and with a staff and equipment equal to that of the best existing schools, even though some of these schools have existed for hundreds of years. Without such a goal it would be unwise even to plan a new school.

"Yes," I repeated rather smugly, "with 50 million dollars we can make a good start." It is interesting, I remember quite precisely, that I said *we* could make

a good start, rather than *you*, but I also know that, on that day at least, I never dreamed that it would happen within my lifetime. It would seem naïve and superstitious to speak of miracles in our materialistic and scientific world. In ancient days, of course, the patriarchs and prophets among our people were constantly in personal communication with the Deity. Miracles, from the bush that burned but was not consumed, to the parting of the sea, were happening all the time. Indeed, in modern Israel I have heard it said, jokingly to be sure, that no one can be so impractical as not to believe in miracles. Now miracles began to happen to us.

The hospital facilities for the poor and needy of New York City had deteriorated during the depression. However, just as the country was beginning to pull itself out of the depression, the war came along, and construction of civilian hospital facilities was abandoned for the duration. When the war was over, Dr. Marcus D. Kogel, the present Dean of the Albert Einstein College of Medicine, was appointed Commissioner of Hospitals for New York City. It was largely through his initiative that the City of New York embarked upon

a hospital construction program, at a cost of something in the neighborhood of 200 million dollars. Under his watchful eyes, the city received its money's worth, dollar for dollar. His great problem, however, was how to implement the new facilities. In accordance with city laws, no money was available for paid salaries to physicians on the staff, except for services such as pathology, chemistry, radiology, and anesthesia. The clinical staffs, entirely voluntary, consisted of city practitioners, most of whom accepted the positions largely for prestige, but devoted a minimum of time to their hospital duties. The only exceptions were those municipal hospitals which were used as medical school teaching facilities, such as Bellevue and Kings County Hospital in Brooklyn.

Dr. Kogel, having heard that a new medical school was contemplated by Yeshiva University, quickly recognized the superior patient care which would result if one of the new city hospitals were offered as a teaching facility to the projected medical school. After considerable negotiation the University and the City of New York agreed that the new Bronx Municipal Hospital Center should become the teaching hospital for the new

Aerial view of the Albert Einstein College of Medicine and the Bronx Municipal Hospital Center, showing: 1. Medical School Building; 2. Library and auditorium wing; 3. Jacobi Hospital; 4. Van Etten Hospital; 5. Residence Hall for house officers; 6. Student Residence Hall and Activities Center; 7. New Science Wing for Research; 8. University Hospital and Diagnostic Center*; 9. New York State Psychiatric Hospital*; 10. Service Buildings for Medical School and Hospitals.*

*Now under construction.



medical school. This Hospital Center was already under construction when the contract was signed.

IN THE BEGINNING

The University, encouraged by this relatively easy jump over the first big hurdle, now actively began to plan a medical-science building on land which it had acquired in the Bronx, across the street from the new Hospital Center. After a nation-wide Committee had been formed, a few of the New York members began to meet at least once weekly. Those were stimulating evenings: the imminence of practical goals did not prevent our flights of fancy into the whole philosophy of medical education. We discussed qualifications for our medical students, the motivation leading to a decision to enter medicine, and the distinction between medical science and medical practice. We investigated the curricula of various medical schools in the country. The whole subject of grading was reviewed. We discussed such details as whether teaching should be done by lecturing, by tutorial

or by instruction in small groups. We chose, of course, all three.

Even now, as I am writing, and our Medical School is selecting students for admission to its eighth consecutive class, many of these problems are still being scrutinized at faculty meetings. And the *pros* and *cons* presented sound like old familiar tunes.

CURRICULUM

Our curriculum is probably closer to the Harvard curriculum than to any other. The school retains the four-year curriculum with the first two years devoted largely to preclinical sciences. The 96 students in each class are divided into groups of eight. Each group has a home room - office - laboratory where teaching is done by an instructor assigned to the group. In addition to the usual first- and second-year courses, instruction is given in genetics, medical statistics, introduction to psychiatry, and a series of lectures in clinical application of basic sciences. Physiology and biochemistry are taught together as integrated disciplines.

Main entrance, Albert Einstein College of Medicine: Student Faculty Lounge on the left, Robbins Auditorium in the center, Science Building on the right.



There were a number of spiritual cornerstones, however, that we laid down in those days which have not changed, and I pray never will. Among these, first was the resolution that in the selection of our students and faculty, we would never have quotas of any kind. There would never be discrimination against people on the basis of race, or sex, or color, or creed, or national or geographic origin. Our criteria for selection would be scholastic achievement and character. Our application blanks were not to contain requests for photographs, for mother's maiden name, for the birthplace of grandfathers, or for any other information that could be used for discriminatory purposes. I am not sure what percentage of the students is Jewish, since we do not ask them, but probably the figure is slightly higher than the proportion of Jewish students in other medical schools in metropolitan New York.

Our second firm resolution was to strive for a degree of excellence which would earn us a place, as soon as possible, among the top medical schools in our country.

ALBERT EINSTEIN

Among the other things we discussed in those days was the name of the school. At first it was tacitly assumed that the school was to be called by what it was, namely, the Yeshiva University College of Medicine. However, many of us were aware of a sense of history about the formation of this school, and it seemed to us that its establishment presented us with an opportunity at the same time to honor the name of some great Jewish scientist, and to emulate him in his achievements. Many names were offered, considered, investigated, and discarded. It was finally decided that if Professor Albert Einstein would permit us to do so, we would name our school for him. I remember so well the cold, damp Sunday in April of 1953 when a group of about 50 people from New York, including Yeshiva University dignitaries, members of our new Board of Overseers, and members of our Medical Advisory Committee, traveled out to Princeton to celebrate the official naming at the home of Professor Einstein. We felt proud and privileged that he had considered our school worthy of his name. In a letter to Dr. Belkin, Professor Einstein declared:

To my mind this undertaking is of greatest importance to American Jewry; it is an act of self-help to make it possible for many of our young people in this country to study medicine. Yeshiva University's medical school will be unique in that, while it will bear the imprint of a Jewish university devoted to the Arts and Sciences and will represent a collective effort by our people to make its contribution in the field of medical science, it will welcome students of all races and creeds.

So it became the Albert Einstein College of Medicine of Yeshiva University. (cont.)



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FACULTY AND STUDENTS

One of the most exciting aspects of this project was the assembling of a faculty worthy of our aims. We could offer neither high salaries, security, nor the prestige of a great university as incentives. We did not even have a completed building. But somehow the new medical college, with opportunities to follow unbeaten paths in teaching, research, and even in patient care, fired the imagination of a few pioneering spirits. The response was naturally greatest from youthful teachers — or at least those who were young in spirit. But in spite of their youth, we succeeded in attracting a number of internationally known medical scientists and clinicians as department heads. They, in turn, gathered younger men and women around them. Thus, within six years after the school began, the research and student laboratories became so crowded that a new wing is now being built.

We all felt that there was something special about the first class, and I believe the students too were aware of the historical position of their class in the school. We had, as a matter of fact, received a considerable number of applications for admission, but many of them were from people who had tried and failed to get into other schools and who thought the opening of a new medical school, which might conceivably have difficulty in obtaining students, would be an opportunity to get past an admissions committee without too much scrutiny. However, most were dedicated young people, not only to medicine, but to history. Considering the possibility that we might fail, it took a good deal of courage for the student who had qualified for admission to an established school, and had been accepted, to prefer to come to us. Many did.

I remember so well the crisp autumn day that classes began. The students were a little shy and self-conscious, as the photographers scrambled over heaps of rubbish and debris outside the unfinished science building to record their arrival for posterity. I remember how the elevators were not yet in order, and the students had to climb five flights of stairs to the anatomy laboratory. I remember how inadequate the heating system was in the middle of that first winter, and how Dr. Joseph Hirsh, Assistant to the Dean, ran all over the Bronx to various department and hardware stores to buy two dozen electric heaters to keep the students' fingers from getting numb while they dissected the cold flesh of the cadavers. I remember that the students had difficulty in finding places to live, and that the wife of the pharmacist at the corner drug-store made herself a voluntary "committee of one" to find furnished rooms for them among the people in the neighborhood. I remember, also, that there was a little grumbling and discontent, but that most students recognized the pioneering character of their class, and stored these early experiences in their memories, to be recalled, I am sure, at future alumni dinners, with the patina of glamour contributed by the passing of time.

EXPANDING

The Albert Einstein College of Medicine is located in the northeast Bronx, unfortunately seven or eight miles away from Yeshiva University, at the confluence of the great highways from New Jersey, Manhattan, Long Island and Westchester. The area is still relatively rural, and the 78 acres on which the school and the hospitals are located still permit room for rolling lawns, trees, shrubs, and flower beds. The College is fortunate, also, that the State of New York has acquired a 125-acre site immediately adjoining it, on which it is bringing to completion a large 70-million-dollar mental hospital.

We lack, for the time being, private hospital facilities, which makes it difficult to attract and to hold faculty in surgery, radiology, pathology, and anesthesiology, but this is being corrected by the imminence of construction of a 250-bed University Hospital, the plans for which are completed and the money largely pledged. This will include a diagnostic and rehabilitation center beyond the in-patient requirements of the hospital.

Since the original Municipal Hospital Center and medical science buildings were constructed, the College has built a dormitory, library, auditorium, and student-faculty lounge. Under construction at the present time are a nurses' training school, the State psychiatric hospital, a large twelve-story addition to our research facilities, the health research building, and the University Hospital. The City of New York is also planning three twenty-one-story buildings with 350 dwelling units, to be rented at low cost to medical school and hospital personnel.

It is obvious that the cooperation of the City of New York, with its 1400 teaching beds, has been indispensable to the founding and successful continuation of our Medical School, but the heart and center of this great evolving medical community is the school itself. We raised all our money through voluntary contributions, largely by the Jewish community in New York and throughout the country. We have a very small endowment, but each year considerable sums are available for scholarships. About 30 per cent of our students receive some financial assistance.

Our graduates have been received by the most outstanding hospitals in the country as interns and residents. The faculty has grown to include nearly 400 full-time members. We have already outgrown our original quarters, and are engaged in an expansion program. We have tried to incorporate the experience of 300 years of medical education in America, and to take an honorable place among the best medical colleges of our country in a mere ten years, and it seems to be succeeding. One day recently I took a visitor from Geneva, Switzerland, a member of the World Health Organization, on a tour of our College. Before we were half-way through, he shook his head and exclaimed: "Only in America!"



*Abraham Mazer Residence Hall,
the student dormitory at the Al-
bert Einstein College of Medicine.*

*The Abraham Jacobi Hospital of
Bronx Municipal Hospital Center,
teaching hospital for the Al-
bert Einstein College of Medicine.*



*The Nathan B. Van Etten Hospital
of the Bronx Municipal Hospital
Center, Teaching Hospital for the
Albert Einstein College of Medicine.*



THE AMA IN POLITICS

Charles S. August '62

Above the hue and cry: A guest editor
and a fourth year student scrutinize
the pressure-group activities of the AMA.

IN midsummer, 1961, President Kennedy sent a letter to Senator Pat McNamara, Chairman of the Special Senate Committee on Aging. This vigorous letter concerned the high priority of the administration's program for medical care to the aged under the Social Security Program. The President's program is embodied in the King-Anderson bill. Hearings in the House Ways and Means Committee began in July, 1961, and one may predict that the floor of Congress as well as committee rooms of both Houses will shortly become arenas for the conflict. Because the legislative branch of the government will be primarily responsible for the President's program, the activities of pressure groups will assume great importance. Foremost among the many groups

will be the American Medical Association.

To many people the terms "lobby" and "pressure group" connote coercion, underhanded dealings, even blackmail and bribe. These are the images created by the muckrakers many years ago and they have not been wholly erased from the public mind. It is the belief of many political scientists that lobbying and pressure-group activity are proper and very necessary aspects of U. S. politics today. V. O. Key of Harvard University, for instance, maintains that a two-party system stimulates the formation of such pressure groups because special interests can find consistent champions in neither party.

The AMA, similar to most pressure groups, is

primarily engaged in activities other than political. It is often a source of highly specialized and expert opinion and is sought by Congress to aid in framing legislation. When it chooses to "press," however, its targets are Congress, executive departments, private groups, organizations, or the American public as a whole. In truth, a really effective pressure group must locate the areas where real decision-making power exists. If, for example, a legislative body has informally delegated some of its power to an administrative bureau, the effective pressure group will quickly shift its activities to the latter.

The United States political system, involving separation of governmental power and biennial elections for two-thirds of the members of Congress, offers multiple foci for pressure-group activity. For example, the AMA's very successful National Education Campaign against compulsory health insurance in 1949, a non-election year, was directed towards many of the largest and most powerful groups in the country: the American Legion, the National Grange, and the American Bar Association. In 1950, an election year, it was directed mainly towards the people as individuals. During both years, the AMA carried on concomitant campaigns for the ears of the President, key members of the Cabinet, senators, and representatives.

One sees little appreciation among the writers who are critical of the AMA today because the AMA's pressure activities occur principally as *responses* to governmental behavior and to attitudes which the AMA regards as threatening. In a sense, the intensity of the AMA's current political passion is a reflection of the fear engendered by governmental aggressiveness in the field of social legislation.

ONE critical variable that will determine the effectiveness of any pressure group is society's attitude towards the group's activities. In other words, in order for the AMA to be effective politically, the public must believe that politicking is a legitimate thing for the AMA to be doing. We must remember that the AMA was founded in 1846. It was not until 1925 that the AMA saw the need to send a representative to Washington during the sessions of Congress. In that year, Herbert Work, Secretary of the Interior, speaking to the House of Delegates, questioned the legitimacy of AMA lobbying. He argued in moralistic terms and concluded, "You don't need any local representative to lobby in Congress for you. In my opinion, it would detract from the dignity of ethical,

scientific medicine to do it." Another observer has criticized the AMA for using the doctor-patient relationship to advance the profession's political aims. This was regarded as a breach of the bond which makes the doctor-patient relationship almost sacrosanct. At the moment, these and similar ethical questions do not seem effectively to be diminishing either the enthusiasm or the amount of AMA political activity.

The AMA has long been accused of obstructing governmental programs for medical care. Indeed, the AMA's Washington office describes its own activities primarily in defensive terms: Their annual report, for instance, published in the *JAMA* of October 22, 1960, states that the program given priority by the Washington office was "the concentration of its efforts in the area of attempting to prevent further governmental inroads into the practice of medicine." It does not seem unreasonable to assert that the public, too, conceives the AMA in terms of obstruction, rather than initiation. In a sense, however, this is almost inevitable. The process whereby a bill introduced on the floor of the House of Representatives becomes law is long and arduous. The bill must be introduced on the floor. Then it may go to a House Committee from which it returns to the floor for debate. If the bill is passed by the House it goes to the Senate where essentially the same process occurs. Finally, when the bill has been debated and passed by the Senate, it goes to the President for his signature. Here the possibility for veto exists. Thus, there are many single points at which a bill may be stalled or killed. A decision-making process organized in this way makes monumental the task of passing a controversial bill. The whole situation is thus especially favorable to groups dedicated to the maintenance of the legislative *status quo*.

One can see, then, that there are certain extrinsic conditions which affect the activities of a political pressure group. Let us now look at the organization itself and see how it functions politically. First, the group has resources, human and material. In 1960, about 180,000 of the nation's 245,000 physicians were members of the AMA. In November of 1948, the AMA levied a \$25 assessment on each member to build a \$3,500,000 "political war chest to fight socialized medicine." By December, 1949, 80 per cent of the members had paid. The AMA has, in addition, another important source of income. It was reported in 1953 that advertising revenue accounted for 35 per cent of the organization's annual income of more than \$9,000,000. At the moment, advertising pages outnumber pages devoted to copy by approximately 2:1. It is estimated now that more than one-half of the AMA's annual income stems from its *Journal* advertisers.

A second determinant of a pressure group's effectiveness is the adequacy of its communication. The chief periodical by which the AMA reaches physicians is, of course, the *JAMA* with a weekly circulation in 1960 of more than 184,000. The *AMA News*, a more informal and abbreviated publication, had, that same year, a circulation of

The author is a fourth-year student. He graduated from Harvard College in 1958 with a major in government. This article, stemming from an undergraduate interest in pressure politics, is adapted from a paper read before the Boylston Medical Society, October, 1961.

267,000. The AMA's monthly for the general public, *Today's Health*, circulates approximately 830,000 copies. (This places it in a class with *Sports Illustrated*, and *Esquire*!) The AMA estimates that *Today's Health* reaches 40 million Americans per month. While all of these publications are primarily concerned with non-political matters, they represent tremendous potential for political communication. There is, however, yet another publication whose editorials seem to be more vigorous and whose pages seem to contain more articles of a political nature than do the other three. This is *The New Physician*, organ of the Student American Medical Association. The monthly circulation of this journal (50,000 plus) rivals the weekly circulation of one of the most widely circulated medical journals in the U.S., *The New England Journal of Medicine*.

Member prestige is another resource which obviously makes a pressure group more effective. This is especially true of groups possessing technical competence where a wide gap exists between the group member and the rest of society. Although it may be argued without much opposition that the prestige of the AMA has fallen, the prestige of the physician as an individual is probably as high as ever. When the doctor cares to act politically on a person-to-person basis, no one doubts his efficacy. Indeed, the AMA's political strategists have stressed repeatedly this very important potential that exists in the personal physician of every member of the U.S. Government.

THE American Medical Association has become a pressure group *par excellence*, and is acknowledged to be a highly successful lobby. Its Washington office is the agency through which direct pressure is brought to bear on the Federal Government. The Washington staff of twenty-four carry on the activities of four AMA divisions. A Communications Division maintains liaison with the press. The Environmental Medicine Division has contact with significant medical posts throughout governmental agencies. The Field Service Division has charge of maintaining contact with members of the House, Senate, and Executive branches of the government. The Legal and Socio-Economic Division studies legislative proposals of medical interest and prepares analyses of bills which specifically interest the AMA. Members of the staff testify at committee hearings, attend conferences on subjects of medical interest both federally and privately sponsored, operate an extensive information service, and supply speakers for civic, collegiate, and medical groups throughout the area. The Washington office prepares a weekly newsletter which is sent to state society officials and others interested in Washington developments. The Association reckons that its Legal and Socio-Economic Division scrutinizes up to 500 bills yearly. In the fiscal year 1959-1960, the Washington office considered more than 450 bills and testified or made written statements on twenty-five. The most important piece of legislation was the Forand Bill. The Executive Vice President was able to report:

The team fighting for the American way of life and the free-enterprise system happily witnessed the House Ways and Means Committee defeat the Forand Bill, H.R. 4700, the measure which would have brought about compulsory health care for the aged via the Social Security System.

A great effort in the field of public relations is an expensive undertaking, both with respect to the energy and the cash involved. The organization of such campaigns have been a good index of how threatened the AMA feels. The organization of the National Education Campaign against compulsory health insurance in 1948 represented pressure-group politicking in its most brilliant form. Carried on by the public relations firm of Whitaker and Baxter, the program was directed in its first year, 1949, towards large national organizations. The rationale for this lay in the fact that Congress, relatively free from constituent pressure in an off-election year, would be more amenable to private group pressure. By the year's end, the AMA claimed the support of 1,829 separate organizations. This number grew to 11,000 during the next year. In 1950, an election year, the National Education Campaign expanded to include a two-week advertising program directed at the public. In the appointed week, every *bona fide* weekly and daily paper in the U.S.A. — 10,033 in all — carried a paid five-column by 14-inch advertisement from the AMA. Sixteen-hundred radio stations broadcast spot commercials. Since the AMA may not openly endorse candidates nor support political campaigns, members received instructions to engage in political activities as individuals. Separate organizations called "Healing Arts Committees" were formed to circumvent the ruling and to campaign against national health legislation.

THE campaign that the AMA waged in 1949 and 1950 had certain features which still characterize many of their pronouncements. Essentially there is a striking absence of rational discussion. The appeals made by the AMA to the public have been primarily emotional. Recently, a speech professor criticized the AMA for just these reasons. At the first AMA Institute held in September, 1961, he pointed out that official statements made by the AMA had been useless to college debate teams that last year debated the subject of compulsory health insurance. He characterized the AMA's arguments as "scare arguments" which, with few exceptions, could not withstand an informed and intelligent attack. He was particularly critical of the AMA's assertion that national health insurance will be a step toward socialism. "Sophisticated people," he stated, "regard this as the most flagrant sort of propaganda — name calling — and it has long since lost its respectability because conservatives have applied it to almost all social legislation."

The moral fervor of the AMA's approach is difficult to ignore. Most observers have interpreted this phe-

nomenon as the result, pure and simple, of a massive threat to the fee-for-service system of medical payments. Since this represents a challenge to the social arrangements in which the leaders of the AMA have gained financial success, prestige, and power, one naturally would expect them to resist the destruction of these arrangements. It seems to me, however, that there is more to it than that. There is a peculiar idealistic passion in the AMA's arguments which, at first glance, is lacking in the pragmatic approach of politicians and other proponents of health insurance legislation. These people argue in terms of economy, of efficiency, or of national interest. Harry Truman epitomized the pragmatic approach in his speech dedicating NIH in 1951. He declared:

At the present time, most people find it very difficult to pay for medical care. . . . Since 1945, I have been proposing to meet this problem by national health insurance. . . . I still believe it is sound and that the Nation would be greatly strengthened by its adoption. . . . I want to make it clear, however, that I am not clinging to any particular plan. What I want is a good workable plan that will enable all Americans to pay for the medical care they need. And I will say here and now that if the people who have been blocking health insurance for five years will come up with a better proposal . . . or even one that is almost as good . . . I'll go along with them. I want to get the job done.

The President here has argued in terms of means, not ends. Implicit in his words, however, is the belief that it is right and proper for people to be provided medical care, and here we come to an important assumption — usually unstated. This is that the right to health is as fundamental a right for Americans as the right to life, liberty, and the pursuit of happiness. J. H. Means discusses this point in the first chapter of his book *Doctors, People, and Government*. He justifies government participation in medicine by invoking the idea that the “pursuit of health is a right of every citizen.” In the hue and cry over the American way of life, it is seldom recognized that this new right has the same kind of justification as do the other so-called rights of man. Ultimately, they are rooted in our almost religious feelings about individualism and individual worth. It is only a short step from the “right to health” to the “right to medical care.” It is this assumption that has been made, consciously or unconsciously, by every proponent of national health insurance. Having made the assumption, basic principles are no longer questioned — or invoked — and these people think mainly in pragmatic terms. This, I feel, is the origin of the matter-of-factness that so characterizes the speech cited above.

Placing health in the category of the rights of man has, I think, involved the transformation of a social desire into a moral imperative. Historically, this process has rep-

resented the development of a consensus. In the U.S. there is, at present, no consensus about this point, and the principal resistance comes from those elements of society which have not accepted the validity of the assumption. (Physicians seem particularly predisposed against the idea of a guarantee of health and freedom from disease. Perhaps this is because physicians, more than most, tend to view illness and death as inevitable and natural.) The AMA's position is that national health insurance represents a diminution in the sum total of freedom in America — particularly their own — and they regard this as an evil to be fought at all costs. What the AMA understands as an issue of conscience, their opponents regard as a matter of efficiency. This, one feels, is what gives the character of non-understanding to the whole controversy. Neither the AMA nor the liberals seem to understand each others' positions. As a result, there is no real possibility for debate, and each accuses the other of bad faith. The literature surrounding the whole issue takes the form of polemics and the whole affair smacks of a holy war.

What is the probable outcome of this holy war? One feels that ultimately there will come to be a consensus assuming the right to health care. (And the U.S.A. seems able to afford such a luxury at the present time.) As more and more physicians come to hold this assumption, the fervor surrounding the issue will taper off. Yet the speed with which the conflict is resolved is most important. One feels it will have a real effect on the quality of American medicine.

The quality of medical care is influenced by the doctor-patient relationship. One of the AMA's main arguments is that the government's holding the purse strings will jeopardize this doctor-patient relationship. However, the AMA asserts that no physician has ever regarded the patient's ability to pay as an important consideration in deciding whether or not to treat. If this is true, then the particular financial arrangement has no necessary or obvious connection to the doctor-patient relationship. This relationship, one feels, boils down ultimately to the interaction of two individuals, one of whom has a problem. If either the patient or the physician is dissatisfied, the relationship is bound to suffer. If the AMA is ploughed under in a great popular movement for compulsory health insurance, those physicians who do not believe that medical care is a fundamental right of every citizen will undoubtedly be resentful. This will lead to a temporary deterioration in the overall quality of American medicine.

I have attempted to point out how the AMA exerts political force and to note certain features of our political process, which condition the activities of pressure groups and predispose them to success. I have also attempted to point out the political principles which surround the conflict of compulsory national health insurance and determine its peculiar character in this country.

References available on request.

Editorial

THE GUILD SPIRIT AND ORGANIZED MEDICINE

On pages 30-33 of this issue, Charles August, a fourth-year student at Harvard Medical School, discusses the role of the AMA in politics today.

It is, of course, just as absurd to consider associations and guilds purely selfish as to believe them purely altruistic. The basic purpose of a guild is indeed self-interest, yet in achieving personal ends the good of society may also be substantially advanced. A guild represents a pact. Society grants a monopoly, and some means of enforcing this favored position. In return the guild must supply a satisfactory quality of service. The concept "satisfactory" is, unfortunately, very indefinite. There has been a continuous tendency, manifest even today, for a guild to maintain that "what is good for our guild is good for the country." This proposition, however, usually arouses struggles to find out *whose* good is involved.

The first medical fraternity dates back to early Greek history, when physicians banded together as the "Sons of Aesculapius." The mythical Aesculapius, great physician, patron of physicians, later a god, had a mortal mother. His father was the god Apollo. When the ancient Greeks (who were ignorant of DNA) wanted to account for genius, the most likely explanation was that some god was the father. And since the Greeks were a very talented people, the Greek gods must have been quite busy. According to Greek mythology, Coronis, after a liaison with Apollo, later consoled herself with a mere mortal. Apollo, quite furious, slew the girl. When she was on her funeral pyre, he relented for the unborn babe. Performing a hurried and not too well described operation, Apollo rescued the unborn infant, Aesculapius, and handed him over to Chiron the Centaur for his education. Chiron, a one-man medical faculty, trained Aesculapius to become the wisest and most skillful of physicians.

Although some later Greek physicians were extremely well educated, medicine in general was a lowly profession. Practitioners were often slaves, or poorly educated, itinerant freemen. To obtain greater recognition and respect, they banded together as the Sons of Aesculapius and depended largely on the prestige of their divine patron.

It is a far cry from the Sons of Aesculapius to present-day medical societies. The modern structure of medical group associations developed by way of the medieval guilds. These guilds, we must recall, were in no sense altruistic. Their basic aim was to regulate competition for the benefit of their own members. They sought monopolies: their members alone, they felt, should be privileged to carry on a particular activity, whether as barber, fishmonger, pharmacist or banker. In return for the monopoly, society exacted certain compensations: the guilds had to guarantee the competence of the workers, and exert "quality control." The history of guilds reveals perpetual conflict between rival groups, between rivals within the same group, and between a favored group and the general public.

By the later middle ages there were three fairly distinct groups competing in medical practice: physicians with long formal university training; apothecaries and barber surgeons with some degree of apprenticeship and experience; and "empirics" or "quacks," without qualification or formal training, who nevertheless treated disease. There were no clear-cut areas of jurisdiction, and truly free competition prevailed. Trained persons, whose services were costly, could not unaided compete with the less well trained, whose services were cheaper. Guilds were needed to establish clear lines of demarcation, prescribe rules of membership, enforce jurisdictional limits, restrict competition and secure monopolies. This could not be achieved without royal assent and cooperation.

In early 15th-century England, a group of physicians petitioned the king to restrict the practice of medicine to those who had attended "scholes of Fisyk"; and, in 1423, a group of physicians and surgeons besought the king to "suppress quacks and empiricks and the knavish men and women who doe presume to practice some

sort of Physick." These petitions were granted, but there was no enforcement. The situation became worse. In 1511, King Henry VIII — presumably at the urging of physicians — lamented that "physick" and surgery were "exercised by a great multitude of ignorant persons of whom the greater part have no manner of insight in the same, nor any other kind of learning . . . to the high displeasure of God, great infamy to the Faculty, and the grievous hurt, damage, and destruction of many of the King's Liege people. . . ." As remedy, King Henry decreed examinations for those who wanted to practice medicine in or near London. It is doubtful that the displeasure of God played any part in this regulation; rather, the displeasure of the physicians was almost certainly the moving force. A full-fledged guild was the only answer. In 1522-23 the College of Physicians was incorporated.

Surgeons had their own organization, but its reputation was not too sweet. The Barbers' Company, established in 1462, had many surgeon members. By 1540, the United Company of Barber-Surgeons was incorporated, giving the surgeons higher professional recognition. However, it seems that they abused their privileges and exploited the monopoly for selfish ends, for in 1542 the king cancelled some of the privileges previously granted because the surgeons refused, so it was alleged, to help the poor. They were "minding only their own lucre, and nothing to the profit or ease of the diseased patient." There is some question whether the neglected poor lodged this complaint, or whether it was the unqualified practitioners who were engaged in some "lobbying" of their own. Presumably it was the latter, who had apparently suffered from the surgeons' monopolistic powers.

Apothecaries, belonging to the Grocers Company, had long tried to secure independent status, and by 1617 achieved separate incorporation as "The Worshipful Society of the Art and Mistery of the Apothecaries." By this time competition among the "medical" guilds was quite severe. Membership qualifications were quite explicit but there was definite conflict over jurisdiction. Each group tried to arrogate to itself as wide an area as possible and accused the other groups of rapacity and selfishness. Meanwhile, the empirics continued to flourish. If the various guilds could not satisfy the vast medical needs of the community — and high fees were one major difficulty — then empirics and quacks rushed in to fill the void.

Perhaps the nadir of professional relationships was reached at the end of the 17th and the early 18th centuries when violent quarrels exploded between the physicians and the apothecaries. It is obvious today that both groups abused the public, and masked atrociously selfish practices by alleged concern for public welfare. The lawsuit between a butcher named Seal, and an apothecary named Rose, became a *cause célèbre*, in which the true antagonists were the College of Physicians and the Society of Apothecaries. As a result of this suit, Parliament broke the monopoly of the physicians' guild over the practice of medicine. Apothecaries were admitted to medical practice, and no longer did they remain, even nominally, the servants who merely carried out the physicians' orders.

It is important to appreciate the similarities between the guilds of medicine and those of other trades and professions. Historically, there have occurred the same jockeying for position, power politics, abuse of monopolies, jurisdictional disputes, and techniques of aggrandizement. Occasionally there have been glaring conflicts with the public interest which required for correction the intervention of community authority. There have also been signal benefits. Each guild must present its own balance sheet.

In general, guilds have been disinclined to change despite environmental changes. The decline of the trade guilds during the industrial revolution, when a new way of life emerged, illustrates a failure of adaptation to circumstances. Present-day events are producing technological and social changes which may affect medical organizations as severely as, in the nineteenth century, industrialization affected the trade guilds. The lesson we should learn from history is that the alternative to adaptation is destruction.

LESTER S. KING '32
GUEST EDITOR

BOOK BANNING

Leon S. Shapiro, M.D.

"We're like a herd of wild horses with blinders over our eyes. On the rampage. Stampede. Over the precipice. Bango! Anything that nourishes violence and confusion. On! On! No matter where. And foaming at the lips all the while. Shouting Hallelujah! Hallelujah! Why? God knows. It's in the blood. It's the climate. It's a lot of things. It's the end, too. We're pulling the whole world down about our ears. We don't know why. It's our destiny. The rest is plain shit. . . ."

THE "dirty" parts of Henry Miller made up some of the ordinarily available sexual literature for most of us in college. I never did read the whole of the *Tropic of Cancer* until I was asked to testify at the Boston book banning trial last summer. I should have. Actually, the psychiatric testimony is irrelevant to the legal issues in the court — as the court properly ruled. What is more horrifying is that the courts should be concerned at all with the fictitious legal issue of the four-letter words which a man uses because he is incapable of dealing with what is overwhelmingly the issue — our apparent determination to blow ourselves to pieces.

My "irrelevant" testimony was quite simple. This is the question I was asked: "Are the sexual descriptions in the *Tropic of Cancer* likely to lead to overt sexual behavior in a normal man?" My answer: I am not an expert on normal men. However, in those cases on which I am expert — those individuals classified as "Sexually Dangerous Persons" in Massachusetts under the 1954 law — the evidence appears to be in the opposite direction: good exciting pornography can facilitate masturbation, for example, and lessen the pressure to engage in various prohibited activities. I suspect that something similar is true for "normal" men. In this respect, the magazine section of *The New York Times*, which is usually filled with crotch-shots in the undergarment ads, is far more provocative than anything in the *Tropic of Cancer*.

Miller, himself, appears "far out" enough in his books to have a unique perspective on some of our cultural values and assumptions. The "I" or "eye" in *The Cosmological Eye*, the *Tropics* books, and the *Air Conditioned Nightmare* is capable of few if any sustained and

deep relationships. Although Miller, himself, appears to have had several lifelong friends, the nihilist hero of Miller's stories can never quite seem to make it.

Many people take issue with Miller's thesis, developed in the *Tropics* and in a series of books written since the early thirties: that our way of life, particularly the preoccupation with money and goods, leads to a progressive cheapening of life and living and eventually to a frenzy of destruction. Miller began to develop these ideas even before we had death camps, a Second World War, or nuclear weapons. And an accurate prophet, no matter how priapic, should be heard.

The *Tropic of Cancer*, for example, has been described as a deliberately structureless anti-novel — a loose series of autobiographical excerpts. But in fact, Miller progresses systematically from an examination of the corrupting effects on the individual from certain kinds of social structures, to a similar examination of the effects in interpersonal relations, in the neighborhood, the city, the world. His works possess a very definite structure and underlying purpose.

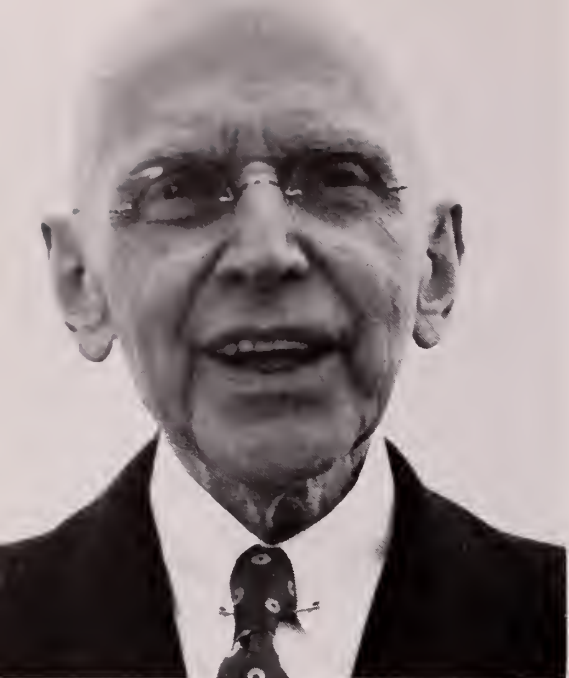
The real tragedy here is not that the book is now "banned" in Massachusetts, for that will naturally increase its sales, but that we should not heed what Miller seems to be saying: that we are worrying blindly about our sexual impulses, while giving full freedom to our aggressive ones. We are not immediately threatened by our ability to create or procreate, but by our ability to destroy.

The barracks humor in the books is sometimes disgusting, sometimes riotously funny and, hopefully, for some a little pornographic. It is rarely trivial. If it's ever a choice between Henry Miller or Hermann Kahn, — the Thermonuclear Clausewitz — make mine Miller. At least we'll die laughing.

Dr. Shapiro has extensive courtroom experience: In 1954, he founded the Massachusetts Division of Legal Medicine — a system of psychiatric services for the courts and prisons. He directed the Division until 1960, when, preferring patient contact to administrative duties, he returned to part-time work at the Norfolk Prison Colony. In addition to prison work and private practice, he teaches at HMS and at the Massachusetts Mental Health Center. (Tempera by Ruth Claff.)

*"... Our apparent determination
to blow ourselves to pieces ..."*





ELLIOTT PROCTOR JOSLIN

1869 — 1962

ELLIOTT PROCTOR JOSLIN '95, Clinical Professor of Medicine, *Emeritus*, at the Harvard Medical School, and past President of the Harvard Medical Alumni Association, died peacefully in his sleep on Sunday, January 28, at his home in Brookline, Massachusetts. He had attended church that morning and, on the preceding day, had taken part in a sound film production for medical teaching entitled, *Diabetes in Youth*. Writing and teaching for the benefit of patients and medical students had continued until the day of his death, illustrating the quotation from Chaucer, engraved in the Elliott P. Joslin Auditorium at the New England Deaconess Hospital: "Gladly would he learn, and gladly teach."

Dr. Joslin grew up in Oxford, Massachusetts. As a boy, he rode horseback to school at Leicester Academy, boarded himself and his horse till Friday, and then rode the 12 miles home. He loved horses, and for years there were polo ponies on his farm, "Buffalo Hill," in Oxford. For more than half a century, the farm was the center of his family life, his first and greatest dedication. His wife, Elizabeth, often welcomed twenty or more members of the family and guests at dinner on a summer Sunday. Mrs. Joslin; three children, Mary, Allen and Elliott; nine grandchildren, and nine great-grandchildren survive him.

After graduating from Yale University, Dr. Joslin studied chemistry under Professor Chittendon for a year.

He entered the Harvard Medical School in 1891 and there wrote his first paper on diabetes. A few years later, as a House Officer at the Massachusetts General Hospital, he reviewed the records of all the diabetic patients admitted to that institution from 1823 to 1898! The study and treatment of diabetes and diabetic patients became his major medical interest. Dr. Joslin was particularly appreciative throughout his life of his teachers and colleagues. Of this period at the Massachusetts General Hospital, he never forgot the influence of Dr. Reginald Heber Fitz, then a Chief of the Medical Service at the MGH.

DR. Joslin began the practice of internal medicine in 1898 and soon joined the staff of the Boston City Hospital. During the next fifteen years, many interns and residents experienced the stimulating influence of his intensely active and inquiring mind. His interests in this period covered a wide field. He wrote, conducted bedside teaching and carried on a far-ranging consultation practice, not only on the subject of diabetes but on gastroenterology, tuberculosis, typhoid fever, and clinical pathology.

As a member of the staff of the New England Deaconess Hospital since its founding in 1897, Dr. Joslin became a revered figure at that hospital. In 1952, he was appointed Honorary Physician-in-Chief, a position he continued to hold until his death.

Thanks to Drs. Frederick G. Banting and Charles H. Best, of the University of Toronto, Dr. Joslin in 1922 received the first insulin in New England. The use of insulin in Boston brought a flood of diabetics to Dr. Joslin. The first patient treated was a nurse, Miss Elizabeth Mudge, whose weight had fallen from 140 to 80 pounds. In connection with this life-

saving discovery, Dr. Joslin often quoted Ezekiel 37: "O ye dry bones . . . I will lay sinews upon you and will bring up flesh upon you . . . and ye shall live."

In 1953, Dr. Joslin established the Diabetes Foundation, Inc., to promote research, teaching and summer camps for diabetic children with gifts from thousands of patients and friends. Camps for diabetic children, initiated in 1927, have grown so that in 1961, the Clara Barton Camp for Girls and the Elliott P. Joslin Camp for Boys gave nearly 500 diabetic youngsters treatment and a camping holiday.

THIRTY years ago, Dr. Joslin bought a tract of land at 170 Pilgrim Road hoping that, at some future time, he might be able to build a clinic for the treatment of diabetic patients. In 1956, with the help of countless friends and grateful patients, the erection of a five-story building on this site by the Diabetes Foundation, Inc., provided space for the 40-bed teaching unit, for library and offices, and for research laboratories, an enduring monument to Dr. Joslin. In this building are also the offices of the doctors comprising the Joslin Clinic.

Dr. Joslin's publications were legion. His books include *Treatment of Diabetes Mellitus* and *A Diabetic Manual*, both of which have appeared in ten editions. From Dr. Joslin's long association with Dr. Francis G. Benedict, Director of the Nutrition Laboratory of the Carnegie Institution, three books concerning the metabolism of diabetes resulted: *Metabolism in Diabetes Mellitus*; *A Study of Metabolism in Severe Diabetes*; and *Diabetic Metabolism with High and Low Diet*.

Among Dr. Joslin's many honors, only a few can be mentioned. He held membership in the American

Academy of Arts and Sciences, Association of American Physicians, American Philosophical Society and many other foreign as well as American societies. He received honorary degrees of Doctor of Science from Harvard University and the University of Toronto, the Distinguished Service Medal of the American Medical Association, Honorary Doctor of Medicine from the Medical Academy of Düsseldorf, the Cross of the Order of Leopold II by the Belgian Government and the Banting Medal of the American Diabetes Association. The Claude Bernard Medal of the International Diabetes Federation (Düsseldorf 1958) carried the inscription of his French honorary titles: "Membre de l'Académie Française, de l'Académie des Sciences, Professeur au Collège de France, au Musée, Commandeur de la Légion d'Honneur."

Dr. Joslin served as Chairman of the Harvard Medical School Library Committee for many years. He instituted the first physical examination for all medical students of the Harvard Medical School, carried out under the chairmanship of Dr. Roger I. Lee '05. While President of the Harvard Medical Alumni Association, and with the assistance of Dr. Francis M. Rackemann '12, he led a campaign for funds which resulted in the building of Vanderbilt Hall Dormitory.

HIS fondness for poetry, for the Bible, and other literature led to frequent quotations, often from William James or Milton, for the benefit of students and residents. Engraved on the walls of the Baker Clinic Research Laboratory appear the following lines, which he selected:

Who learns and learns
But does not what he knows
Is one who plows and plows
Yet never sows.

Dr. Joslin derived the greatest satisfaction from translating the results of laboratory and clinical research into improved methods of treatment for his patients.

HOWARD F. ROOT '19

